

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02677

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>Howard</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		LENGTH OF STAY (in this place) <u>4 1/2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Guilford Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Norman</u> (First) <u>Newton</u> (Middle) <u>Akers</u> (Last)		4. DATE OF DEATH <u>March 18</u> (Month) <u>18</u> (Day) <u>1951</u> (Year)		5. AGE last birthday <u>49</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.	
6. SEX <u>M</u>	7. COLOR OR RACE <u>W</u>	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	9. DATE OF BIRTH <u>July 18, 1901</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maulden helper</u>	
11. FATHER'S NAME <u>Littleton Akers</u>		12. MOTHER'S MAIDEN NAME <u>Mildred Shumate</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		15. SOCIAL SECURITY No. <u>—</u>		16. INFORMANT AND ADDRESS <u>Miss Lillie Akers, Savage Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 19, 1951, to Mar. 18, 1951, that I last saw the deceased

alive on Mar. 18, 1951, and that death occurred at 6 a. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 3/20/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

970 916



VS. A15

ADDRESS

100105 Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 195

02679

1. PLACE OF DEATH: COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Scaggsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Scaggsville</u>	
TOWN <u>Scaggsville</u>		TOWN <u>Scaggsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route #1, Laurel, Md</u>		STREET ADDRESS (If rural, give location) <u>Route #1, Laurel, Md</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>RACHAEL</u>	(Middle) <u>ELIZABETH</u>	(Last) <u>BENTLEY</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>18</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 23, 1868</u>
9. AGE last birthday <u>82</u> yrs.	If under 1 year Months <u> </u> Days <u> </u>	If under 24 hrs. Hours <u> </u> Min. <u> </u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Robert Jackson</u>	14. MOTHER'S MAIDEN NAME <u>Susan Elymer</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>	16. SOCIAL SECURITY NO. <u> </u>	17. INFORMANT AND ADDRESS <u>Mr. Frank Raper, Silver Spring, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

420.1 Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause,
stating the underlying cause last

(a)

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

3 days

3 yrs.

1 wk.

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 6, 1951, to Mar. 18, 1951, that I last saw the deceasedalive on Mar. 18, 1951, and that death occurred at 3 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

02680

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elbridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elbridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2103 Furnace ave</u>		STREET ADDRESS (If rural, give location) <u>2103 Furnace ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u> (Middle) <u>Mourae</u> (Last) <u>Flood</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>24</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 4, 1859</u>
9. AGE last birthday <u>91</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Elbridge Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Flood</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Miss J. Flood 2103 Furnace ave</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

422.1
932

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

1 week

15 yrs

10 yrs

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 17, 1951, to March 24, 1951, that I last saw the deceasedalive on March 23, 1951, and that death occurred at 12:15 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 26, 1951 Dr. B. B. Rumbaugh 3609 Main St Elbridge Md
Miss E. Bud Vellin Henry W. Jenkins & Son Co. 4905 York Rd. 541506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

02681

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> TOWN <u>Rural</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Montgomery Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> TOWN <u>Rural</u> STREET ADDRESS (If rural, give location) <u>Montgomery Road</u>	
3. NAME OF DECEASED (Type or Print) <u>HENRY</u> (First) <u>BERNARD</u> (Middle) <u>FROMME</u> (Last)		4. DATE OF DEATH <u>March 8, 1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 14, 1882</u>
9. AGE last birthday <u>69</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing Supply</u>
11. BIRTHPLACE (State or foreign country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>?</u>
14. MOTHER'S MAIDEN NAME <u>Kaiser</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-01-3449</u>		17. INFORMANT AND ADDRESS <u>Gertrude L. Fromme, Ellicott City, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>Immediate</u>
Antecedent cause(s) (b) <u>Myocardial Infarction</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>2 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 10, 1947, to Mar 8, 1951, that I last saw the deceased alive on Mar 6, 1951, and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar. 12, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	LOCATION (City, town, or county) (State) <u>Ellicott City, Md.</u>
DATE REC'D BY LOCAL REG. <u>3-10-51</u>	REGISTRAR'S SIGNATURE <u>John B. Loughran, Jr.</u>	24. FUNERAL DIRECTOR <u>Easton Sons, Ellicott City, Md.</u>	ADDRESS <u>B. E. L.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

513687



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02682

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Laurel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Laurel</u> <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Scaggsville</u>		STREET ADDRESS (If rural, give location) <u>Scaggsville</u>	
3. NAME OF DECEASED (Type or Print) <u>Enylis</u> (First) <u>Father</u> (Middle) <u>Estie</u> (Last) <u>Siddings</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>3/8/51</u>
9. AGE last birthday <u>3</u> yrs. <u>8</u> Months <u>2</u> Days <u>2</u> Hrs. <u>5</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Laurel, R. + D., Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Norman W. Siddings</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Ann Lee Siddings</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Norman W. Siddings, Laurel, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>maternal nephritis</u>			
Antecedent cause(s) (b) <u>769.0</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>161c</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

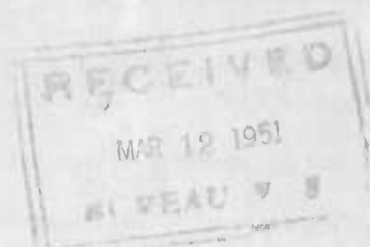
22. I hereby certify that I attended the deceased from 3/21, 1951, to 3/8, 1951, that I last saw the deceased alive on 3/8/51, 1951, and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE <u>B. W. Warr</u> (Degree or title)		ADDRESS <u>Laurel, Maryland</u>	
DATE SIGNED <u>3/8/51</u>		DATE SIGNED <u>3/8/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Shankshy</u>		<u>Norman W. Siddings, acting</u>	
<u>20308131440V</u>		<u>Laurel, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

02683

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ellicott City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pinel Clinic</u>		STREET ADDRESS (If rural, give location) <u>5508 Narcissus Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harvey</u>	(Middle) <u>E</u>	(Last) <u>Householder</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 10 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Baltimore</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Continental Can Co.</u>	9. AGE last birthday <u>66</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mrs Mary Householder 5508 Narcissus Ave Balto</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral thrombosis</u>			<u>15 days</u>
Antecedent cause(s) (b) <u>Hypertensive arteriosclerotic cardio vascular disease</u>			<u>24 years</u>
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 24</u> , 19 <u>51</u> , to <u>Mar. 14</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Mar. 14</u> , 19 <u>51</u> , and that death occurred at <u>11.05 P.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Irving J. Taylor M.D.</u>		ADDRESS <u>4101 Edmund Ave</u>	
DATE SIGNED <u>3-16-51</u>		DATE SIGNED	
23. BURIAL, CREMATION, REPAVAL (Specify)		DATE THEREOF	
24. FUNERAL DIRECTOR		LOCATION (City, town, or county) (State)	
25. REGISTRAR'S SIGNATURE <u>David Redick</u>		26. FUNERAL DIRECTOR <u>Harry H. Nix</u>	
ADDRESS <u>390346</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 192

02684

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u> LENGTH OF STAY (in this place) <u>27 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>George</u> (Middle) <u>William</u> (Last) <u>Hurt</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>3</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 10, 1878</u>
9. AGE last birthday <u>72</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>John A. Hurt</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>none</u>		14. MOTHER'S MAIDEN NAME <u>Helene Kendrick</u>	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. Ida B. Hurt - Sykesville, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinoma of the Prostate Gland</u>			
Antecedent cause(s) (b) <u>giving rise to the above cause stating the underlying cause last</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Rural Sykesville</u> CITY OR TOWN <u>Sykesville</u> (COUNTY) <u>Howard</u> (STATE) <u>MD</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>46</u> , to <u>Mar 3</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Mar 2</u> , 19 <u>51</u> , and that death occurred at <u>9:50 P.</u> m. from the causes and on the date stated above.			
SIGNATURE <u>H. A. Barnes MD</u> (Degree or title)		ADDRESS <u>Sykesville</u> DATE SIGNED <u>3/4/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-6-51</u>	
DATE REC'D BY LOCAL REG. <u>Mar. 5, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>St. John</u> LOCATION (City, town, or county) <u>Howard Co., Md.</u> (State)	
REGISTRAR'S SIGNATURE <u>Alison A. Platt</u>		24. FUNERAL DIRECTOR ADDRESS <u>C. H. Miller - Sykesville, Md.</u>	

100105

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
MAR 18 1961
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *1-91*

1. PLACE OF DEATH - COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pinel Clinic</u>		STREET ADDRESS (If rural, give location) <u>2667 Edmondson Ave.</u>	
3. NAME OF DECEASED (First) <u>Frank</u> (Middle) <u>Jendrek</u> (Last) <u>Jendrek</u>		4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 31 1881</u> 69 yrs.
9. AGE last birthday <u>Mar. 31 1881</u> 69 yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Jendrek</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Westphal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>213-09-7509</u>	
17. INFORMANT AND ADDRESS <u>Leo Jendrek 2667 Edmondson Ave.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cerebral changes due to neoplasm</u>	<u>6 weeks</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Metastasis from rectum to brain and pelvis</u>	<u>?</u>
	(c) <u>Carcinoma of rectum</u>	<u>2 1/2 years</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 2/21, 1951, to 3/8, 1951, that I last saw the deceased alive on 3/8, 1951, and that death occurred at 6:05 P. m., from the causes and on the date stated above.

SIGNATURE Living J. Taylor M.D. (Degree or title) ADDRESS Pinel Clinic Ellicott City, Md. DATE SIGNED Mar 8, 51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar. 12 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	LOCATION (City, town, or county) <u>Baltimore Maryland</u>
DATE REC'D BY LOCAL REG. <u>3/9/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Redneck</u>	24. FUNERAL DIRECTOR <u>John T. Stansbury</u>	ADDRESS <u>2700 Edmondson Ave.</u>

51

670658

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

BIRTH NO.				REGISTERED No. 191			
1. NAME OF DECEASED (Type or Print) <i>Mrs. Caroline L. Johns</i>				2. DATE OF DEATH <i>March 17, 1951</i>			
3. PLACE OF DEATH: A. <i>Baltimore, MD.</i> Maryland <i>Elkridge (Howard Co.)</i>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Howard</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Elkridge</i>			
c. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location) <i>Landing Road</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>		8. DATE OF BIRTH <i>12-4-1892</i>		9. AGE (in years, last birthday) <i>58</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>D.H. Heezen</i>				14. MOTHER'S MAIDEN NAME <i>Caroline Reesink</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>Richard Johns, Raleigh, N. C.</i>			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>(A) Generalized abdominal carcinomatous</i>				<i>? 5 mo.</i>			
DUE TO							
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>(B) Carcinoma of ovary</i>				<i>10 mo.</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>(C) Terminal intestinal obstruction</i>				<i>1 week</i>			
19A. DATE OF OPERATION <i>May 11, 1951</i>				19B. MAJOR FINDINGS OF OPERATION <i>Carcinoma of ovary</i>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12-2-1950</i> to <i>March 17, 1951</i> , that I last saw the deceased alive on <i>March 16, 1951</i> , and that death occurred at <i>9:05</i> a.m., from the causes and on the date stated above.							
23A. SIGNATURE <i>A. J. Sullivan</i>				23B. ADDRESS <i>1114 St Paul St</i>		23C. DATE SIGNED <i>Mar 17, 1951</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>3-19-51</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Oakwood Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Raleigh, N.C.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>3/18/51</i>		REGISTRAR'S SIGNATURE <i>John B. Loughan</i>		25. FUNERAL DIRECTOR ADDRESS <i>F.C. Higinbotham, Ellicott City, Md.</i>			

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02687

Reg. Dist. No. 194

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Clarksville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Clarksville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last) <u>Martha Elizabeth Johnson</u>		(Month) (Day) (Year) <u>March 1, 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1-9-1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel E. Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Harding</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Family Records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) _____		
Antecedent cause(s) (b) <u>Arteriosclerotic heart disease & hypertension</u>		<u>10 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>12/23, 1946</u> , to <u>3/1, 1951</u> , that I last saw the deceased alive on <u>2/28, 1951</u> , and that death occurred at <u>10:56 a.m.</u> , from the causes and on the date stated above.		
SIGNATURE <u>Charles S. Whitaker, M.D.</u>		DATE SIGNED <u>3/3/51</u>
23. BURIAL CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>3-4-51</u>	<u>Linthicum Chapel</u>
LOCATION (City, town, or county) (State)	<u>Clarksville, Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-3-51</u>	REGISTRAR'S SIGNATURE <u>Mario A. Whitaker</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 7 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02688

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

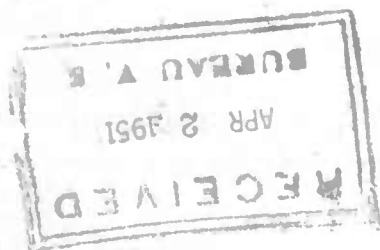
Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>Howard</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>	
TOWN <u>Savage</u>		TOWN <u>Savage</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Florence</u> (Middle) <u>Benn</u> (Last) <u>Benn</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>29</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>June 30, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>73</u> yrs. If under 1 year Months Days Hours Min.
13. FATHER'S NAME <u>John Phelps</u>		11. BIRTHPLACE (State or foreign country) <u>Savage, Md.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Emma</u>	
16. SOCIAL SECURITY No. <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
17. INFORMANT <u>Miss Louise Athey, Bentonsville, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Hypertensive Cardio-Vascular Dis.</u>				<u>2 yrs.</u>	
Antecedent cause(s) (b) <u>Diabetes</u>				<u>3 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Common Cold</u>				<u>2 wks.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>✓</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>		PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar. 17, 1951</u> , to <u>Mar. 29, 1951</u> , that I last saw the deceased alive on <u>Mar. 29, 1951</u> , and that death occurred at <u>1 a. m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Frank Shipley, M.D., Savage, Md.</u>		ADDRESS <u>1 a. m.</u>		DATE SIGNED <u>3/31/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3/31/51</u>		NAME OF CEMETERY OR CREMATORY <u>Long Hill Cemetery</u>	
LOCATION (City, town, or county) <u>Laurel, Maryland</u>		(State) <u>Md.</u>			
DATE REC'D BY LOCAL REG. <u>3/31/51</u>		REGISTRAR'S SIGNATURE <u>Frank Shipley</u>		24. FUNERAL DIRECTOR <u>W. W. With, Donaldson, Laurel, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

02689

Reg. Dist. No. 190

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Elkridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkridge</u> 27	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Route 1 1/4 mi. North of Dorsey light</u>		STREET ADDRESS (If rural give location) <u>Montgomery Road, RFD 4 Box 111</u>	
3. NAME OF DECEASED (Type or Print) <u>Nellie Richardson</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>20</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>None</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Howard County Welfare, Ellicott City, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Immediate cause</u> <u>Compound, Comminuted skull fracture; chrushed chest</u>		<u>Instant</u>
(b) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>8/2.5 170c</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Multiple fractures of pelvis and extremities</u>		<u>Instant</u>
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>U.S. Route 1</u>	(CITY OR TOWN) <u>Rural Elkridge</u> (COUNTY) <u>Howard</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3:20</u> <u>1951</u> <u>6:50</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Struck by auto while on foot on U.S. Route</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE George E. Burdick M.D. (Degree or title)
 DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY
 ADDRESS Ellicott City, Md. DATE SIGNED 3-20-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-24-51</u>	NAME OF CEMETERY OR CREMATORY <u>Gaines</u>	LOCATION (City, town, or county) <u>Elkridge, Md</u>	(State) <u>Md.</u>
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DATE REC'D BY LOCAL REG. <u>March 24, 1951</u>	REGISTRAR'S SIGNATURE <u>Miss E. B. ...</u>	24. FUNERAL DIRECTOR <u>F.C. Higinbotham, Ellicott City, Md.</u>	ADDRESS <u>Ellicott City, Md.</u>
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02690

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge, Md</u>	
TOWN <u>1946 Furnace ave</u>		TOWN <u>Furnace Rd 1946</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joseph</u> <u>CHAPMAN</u> <u>RILEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>11</u> <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Dec 1, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	9. AGE last birthday <u>59</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>AMERICA MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH CARSON RILEY</u>		14. MOTHER'S MAIDEN NAME <u>ALICE BREWER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>210-16-2884</u>	
17. INFORMANT <u>Mrs Nellie Riley</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Hemorrhage of stomach</u>				<u>20 minutes</u>	
Antecedent cause(s) <u>Chronic ulcerative gastritis due to</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cancer of Tongue</u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>malignancy of Tongue</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>OF INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from November 50, 1950, to March, 1951, that I last saw the deceased alive on 1 March, 1951, and that death occurred at 4:15 P.m., from the causes and on the date stated above.

SIGNATURE <u>George Edwin Goble</u>		ADDRESS <u>11 March 51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3/14/51</u>	
NAME OF CEMETERY OR CREMATOR <u>Meadowridge</u>		LOCATION (City, town, or county) (State) <u>Dorsey Md.</u>	
DATE REC'D BY LOCAL REG <u>3-12-51</u>		REGISTRAR'S SIGNATURE <u>A W Neelick</u>	
24. FUNERAL DIRECTOR <u>John J. Gowan</u>		ADDRESS <u>John J. Gowan</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1908
March
1908

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

02691

Reg. Dist. No. 190

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Elkridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> # <u>H</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1934 Elkridge Heights Ave.</u>		STREET ADDRESS (If rural give location) <u>3128 Remington Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u> (Middle) <u>Henry</u> (Last) <u>Vogt</u>	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>19</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct. 11, 1879</u>
9. AGE last birthday <u>71</u> yrs.		10. If under 1 year Months <u>3</u> Days <u>19</u> Hours <u>19</u> Mins. <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter & Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>odd jobs</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Are</u>	
13. FATHER'S NAME <u>Jacob Vogt</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Goldner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>214-14-1151</u>	
17. INFORMANT <u>Mrs. Mellic R. Vogt</u>		18. ADDRESS <u>3128 Remington Ave.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>instant</u>	
(a) Immediate cause <u>Coronary Thrombosis</u>			
(b) Antecedent cause(s) <u>420.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
(c) <u>94a</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>George E. Bunting</u> M.D.		DATE SIGNED <u>3-19-51</u>	
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/22/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Landon Pk.</u>		LOCATION (city, town, county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG. <u>3/2/51</u>		24. FUNERAL DIRECTOR <u>M. J. Tiekner & Sons</u> ADDRESS <u>570246 Balto 17 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02692

Reg. Dist. No. 195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Savage</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Life</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) <u>Thaddens</u> (First)		<u>Eugene</u> (Middle)		<u>Welch</u> (Last)		4. DATE OF DEATH <u>March 19</u> 19 <u>51</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 18, 1881</u>	9. AGE last birthday <u>69</u> yrs.	If under 1 year		If under 24 hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton mill</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas B. Welch</u>				14. MOTHER'S MAIDEN NAME <u>Susan Parrell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>Francis R. Welch Savage Md</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Cerebral Haemorrhage</u>						<u>4 days</u>	
(b) Antecedent cause(s) <u>Arterio-sclerosis</u>						<u>3 yrs.</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last							
11. OTHER SIGNIFICANT CONDITIONS <u>Common Cold</u>						<u>1 wk.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 15, 1951</u> , to <u>Mar. 19, 1951</u> , that I last saw the deceased alive on <u>Mar. 19, 1951</u> , and that death occurred at <u>10 a.</u> m., from the causes and on the date stated above.							
SIGNATURE <u>Frank Shipley, M.D.</u>				ADDRESS <u>Savage, Md.</u>		DATE SIGNED <u>3/20/51</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar. 21, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lanesh, Maryland</u>	
DATE RECD BY LOCAL REG. <u>3/20/51</u>		REGISTRAR'S SIGNATURE <u>Frank Shipley,</u>		24. FUNERAL DIRECTOR <u>Dr. W. H. Donaldson</u>		ADDRESS <u>Lanesh, Md</u>	

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